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SHARP: Bringing HAIs into Focus

Surveillance for Healthcare-Associated and Resistant Pathogens Unit, Michigan Department of Community Health

www.michigan.gov/hai

In this issue

What's New with the SHARP Unit

Happy Retirement!

At the end of the July, Judy Weber retired after 5 1/2 years as the Healthcare Facility Liaison with the SHARP Unit. She has been with the SHARP Unit since it was created in 2009, and even came up with the name!

Judy has had an illustrious career in public health including 1 1/2 years at the MDCH laboratory, 12 years in MDCH Epidemiology and Disease Control, 13 years with MDCH HIV Prevention, and 6 years as an EPC for Mid-Michigan District Health Department prior to joining the SHARP Unit.

We will definitely miss her and wish her well in her retirement!

African Ebola Outbreak

The largest outbreak of Ebola Virus Disease (EVD) ever documented is currently occurring in West Africa (Guinea, Sierra Leone, Liberia and Nigeria). For the most up-to-date case count visit: http://www.cdc.gov/vhf/ebola/outbreaks/guinea/index.html. EVD poses little risk to the U.S. general population at this time. However, U.S. healthcare workers are advised to be alert for signs and symptoms of EVD in patients with compatible illness who have a recent (within 21 days) travel history to countries where the outbreak is occurring, and should consider isolation. Here's what you need to know about EVD in the US.

Case Definition and Recognition

For the most up to date Case Definition visit: http://www.cdc.gov/vhf/ebola/hcp/case-definition.html. Early recognition and identification of suspect EVD patients is critical. Suspect patients should be immediately placed in isolation or a single patient room with private bathroom and door closed. EVD is characterized by sudden onset of fever (≥ 101.5° F) and malaise, accompanied by one or more of the following: • myalgia • severe headache • abdominal pain • vomiting • diarrhea

Patients may progress to develop more severe signs or symptoms including hemorrhagic symptoms (petechia, ecchymosis, bruising) and multi-organ dysfunction, including hepatic damage, acute kidney disease, and central nervous system involvement, leading to shock and death.
The MDCH Interim Guidelines for Evaluation of US Patients Suspected of Having Ebola Virus Disease are available at: http://michigan.gov/documents/emergingdiseases/Michigan_EBOLA_Guidance_464829_7.pdf?20140812103615.

Infection Control

U.S. hospitals can safely manage a patient with EVD by following recommended isolation and infection control procedures, including standard, contact, and droplet precautions. Early recognition and identification of patients with potential EVD is critical. Any U.S. hospital with suspected patients should follow CDC's Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in U.S. Hospitals (http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html). These recommendations include information on the following:

- Patient placement
- Healthcare provider protection
- Aerosol-generating procedures
- Environmental infection control

Additional guidance on EVD for healthcare workers can be found at: http://www.cdc.gov/vhf/abroad/healthcare-workers.html.

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CDI Prevention Initiative

Phase 2 of the prevention initiative has recruited 12 acute care facilities and 14 skilled nursing facilities. The skilled nursing facilities have begun the process of enrolling in the NHSN Long Term Care Component, and the acute care facilities continue entering their data into NHSN. All facilities need to confer rights to us so that we are able to view their data entries and provided analysis. Evergreen Living Center (St. Ignace) and Hazel Finley Country Manor (St. Johns) have successfully enrolled in NHSN and are entering their data. Big congratulations to them! We are encouraging our remaining 12 skilled nursing facilities to complete the enrollment process.

The value of entering the data into NHSN by acute care and skilled nursing facilities provides facilities with a customized system to track infections in a streamlined, systematic way. This is a significant step by our prevention partners to prevent CDI, improve patient care, and decrease costs.

In Phase 2, we are not asking facilities to track MRSA infections. Facilities are welcome to enter those data, but we will not collect and analyze MRSA data in Phase 2 of the Initiative.

In the weeks ahead, we will continue to assist facilities with NHSN enrollment and site visits will be scheduled. I look forward to seeing all CDI Prevention Champions and meeting to discuss their work on CDI action plans.

If you would like to learn more about the CDI Prevention Initiative, please contact:

Gail Denkins, CDI Prevention Initiative Coordinator
DenkinsG@michigan.gov or
(517) 241-3638

NHSN Surveillance Update

Version 8.2 of NHSN was released in late July, 2014. Changes are as follows.

For All NHSN Components:

- A new print option is now available for saved records.
- Output formatting is available for any custom output set (HTML, PDF, CSV, RTF, Excel).
- The NHSN Help Online Manual has been updated and is available.

Patient Safety Component:

- There are new alerts and analysis options for unusual susceptibility profiles. These include twelve unusual susceptibility profiles when reported for in-plan events. The output options can be found in the advanced folder with the pathogen-level data sub-folder. For more information, see: http://www.cdc.gov/nhsn/PDFs/USP-Alert-current.pdf.
- Facilities will no longer have to re-confer rights when they add a new location in NHSN. The facility will be alerted that this update occurred, but no action will be required.
- There are now two methods of importing procedure data via CSV file: 1) without a header row in the same order as described in the import documentation or 2) with a header row in any order.
- Descriptions supplied with each ASA score have been updated to reflect the current descriptions defined by the American Society of Anesthesiologist's classification of physical status.
- Users can now enter a patient weight up to 999.9 lbs when reporting procedure-level data.

Patient Safety Analysis:

- The "CMS Reports" output option folder has been moved and now appears above the "Advanced" folder. Additional subfolders have been created for each CMS Reporting Program.
- PPS-Exempt Cancer Hospitals can now run SSI SIRs specific to the PPS-Exempt Cancer Hospital Quality Reporting Program requirements.
- Procedures with a closure technique of "Other" will no longer have a risk model value calculated, and will continue to be excluded from SIRs and SSI rate tables

Healthcare Personnel Safety Component:

- IRF Units mapped as locations of an acute care hospital can now enter individual monthly reporting plans and submit summary influenza vaccination data separately to fulfill the CMS Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) requirements.

Long Term Care Component:

- Analysis output options have been added, including a linelist and rate table

Clinical Document Architecture:

- NHSN is now able to accept CDA imports for Antimicrobial Resistance (AR) numerator and denominator. There is no manual entry for AR data. Details regarding the AR option of the Antimicrobial Use and Resistance (AUR) Module can be found here: http://www.cdc.gov/nhsn/acute-care-hospital/aur/index.html.

-Allison Murad, MuradA@michigan.gov

Voluntary HAI Reporting in Michigan

The SHARP Unit has built a voluntary system for healthcare-associated infections (HAI) surveillance using the National Healthcare Safety Network (NHSN). The Centers for Medicare and Medicaid Services (CMS) requires hospitals to report certain HAIs into the NHSN; however, only unusual occurrences, outbreaks, and epidemics of most HAIs are required to be reported to MDCH according to Michigan's CD reporting rules. As part of an ongoing CDC funded program, the SHARP Unit receives voluntarily reported data through NHSN from 97 of 168 (57%) hospitals in Michigan.

Michigan NHSN data are analyzed both individually and in aggregate. Overall data are released on a quarterly, semi-annual, and annual basis. Only aggregate data are released to the public, but each participating hospital receives individualized data reports semi-annually. Aggregate reports and sample individual reports can be found at www.michigan.gov/hai. Hospitals are encouraged to provide data to the public; however, MDCH SHARP will not share hospital-identified data due to signed data use agreements (DUAs) with each participating hospital.

A recent series of MLive articles (http://topics.mlive.com/tag/hospital-infections/posts.html) suggest that some media and patients desire mandatory and public reporting of HAIs in Michigan. This series profiled a few patients from Michigan who have acquired an HAI from a hospital, and interviewed infection preventionists throughout Michigan regarding mandatory reporting. An article in the series states that the "MLive Media Group is calling on state lawmakers to require hospitals and the Department of Community Health to prominently disclose infection rates, even beyond the six federal categories." It claims that "Michigan is among the least forthcoming states in the nation." Although Michigan does not have a reporting mandate, hospital-specific CMS data that is collected is reported on hospital compare (http://www.medicare.gov/hospitalcompare).

MDCH SHARP continues to increase the number of hospitals voluntarily sharing data with the unit. Participating hospitals continue to increase the number of infection types reported, whether required as a condition of participation in the national program or not, as well as the number of locations or types of surgeries. Data have shown that those hospitals who have reported the longest, particularly for central line-associated bloodstream infections (CLABSIs) and catheter-associated urinary tract infections (CAUTIs), maintain lower than average standardized infection ratios (SIRs) than both statewide and national data. These hospitals reported HAI data prior to any required reporting, and continue to experience success.

A culture of trust has been established between hospitals, the MDCH SHARP Unit, and other organizations such as the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality, and MPRO, Michigan's quality improvement organization. Hospitals are willing to openly discuss infections, infection prevention, and HAI surveillance in their facilities. This culture has been a leading factor in the low incidence of HAIs in Michigan. Collaboration, prevention, and openness have created an environment in Michigan where extensive HAI surveillance data are available on a voluntary basis.

-Allison Murad, MuradA@michigan.gov

Ebola Outbreak

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Laboratory Specimen Guidance

If testing is indicated, immediately notify MDCH (517-335-8165 during normal business hours, 517-335-9030 after hours, weekends, and holidays). Healthcare providers should collect serum, plasma, or whole blood in plastic tubes. Serum should be collected in a red top or serum separator tube and whole blood collected in a purple, green, or blue top tube. A minimum sample volume of 4 mL of serum, plasma, or whole blood should be shipped refrigerated on ice packs, or serum or plasma may be sent frozen on dry ice, by overnight delivery in accordance with federal and international guidelines to the Michigan Department of Community Health's Bureau of Laboratories (http://www.michigan.gov/mdch/0,4612,7-132-2945_5103---,00.html). MDCH will forward specimens to the CDC. Requisition forms for both MDCH and CDC must accompany the specimen. Specimens will not be tested without prior MDCH approval.

MDCH has posted guidance for specimen collection and submission, including necessary forms, for clinical laboratories at http://www.michigan.gov/documents/mdch/Ebola_Updat_1_8-7-2014_464958_7.pdf.

CDC has also posted Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Patients with Suspected with Ebola Virus Disease at http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html.

Updates

This is a rapidly evolving situation and we anticipate that CDC will continue to update their Ebola guidance and thus would advise monitoring their website at: http://www.cdc.gov/vhf/ebola/index.html.

-Noreen Mollon, MollonN@michigan.gov

Events/Calendar

Please visit our SHARP Unit Calendar, found on the SHARP Unit homepage. If you would like to add an event to this calendar, please email: MDCH-SHARP@michigan.gov

Helpful Links

www.michigan.gov/hai

www.mhakeystonecenter.org

www.mpro.org

www.mi-marr.org

www.msipc.org

www.apic.org

www.hhs.gov/ash/initiatives/hai/

www.hospitalcompare.hhs.gov

www.cdc.gov/nhsn

www.cdc.gov/HAI/prevent/prevention.html

www.cdc.gov/HAI/organisms/cre

www.cdc.gov/HAI/organisms/cdiff/Cdiff_infect.html

CRE Surveillance and Prevention Initiative

CRE Surveillance and Prevention Initiative Gearing Up for Phase 2
The CRE Surveillance and Prevention Initiative was successful at maintaining enrollment of all 21 facilities. We enrolled 8 new facilities to join us (6 acute care facilities and 2 long-term acute care facilities). This brings our overall total to 29 facilities participating in the Initiative. Phase 2 begins September 2014 and will continue through February 2016. Phase 2 will have a heavier focus on regional collaboration and partnerships. Meetings will be held to assist facilities across the healthcare continuum with communication of patient status, smoother transitions of patient between facilities and providing information on each other's prevention plans. Partners will be sharing their prevention plans with each other to create a better sense of regional collaboration.

New Facility Orientation
Brenda held an 'new facility orientation and CRE Prevention Plan ideas' webinar in July. All new facilities and a few current facilities participated. CRE Prevention Plans for Phase 2 are due to Brenda by August 29th.

CRE Partners in Prevention Quarterly Call
The quarterly CRE Partners in Prevention call is scheduled for September 17th at 2:00pm. This will be the first call joining all facilities - kicking off Phase 2. Brenda is working on securing speakers.

CRE Incidence in Michigan
Three hundred and eight cases have been reported by participating facilities since September 2012. A majority of cases have been inpatient (non-ICU) cases. CRE incidence currently is 0.81 cases per 10,000 patient-days which is a decrease from our baseline rate of 1.07. -Brenda Brennan, BrennanB@michigan.gov

Acute Care	Baseline	Intervention	p-value
Number of Cases	94	192	---
Number of Patient-Days	931,782	2,402,306	---
Incidence Rate	1.01	0.80	**0.07**
LTAC	**Baseline**	**Intervention**	**p-value**
Number of Cases	8	5	---
Number of Patient-Days	27,281	73,775	---
Incidence Rate	2.93	0.68	**0.01**
Overall	**Baseline**	**Intervention**	**p-value**
Number of Cases	102	197	---
Number of Patient-Days	959,063	2,476,081	---
Incidence Rate	1.06	0.80	**0.02**

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